

REGISTRATION FORM - IName: _____
First Middle Initial Last Degree(s)

Title: _____

Name: _____
As you wish it to appear on name tag

Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

E-mail: _____

I have special needs. They are: _____

☐ Purchase order enclosed **(provide P.O. # or a copy of actual P.O.)*** P.O. # _____☐ Check enclosed (Please make check payable to ASTCDPD) Tax ID Number 73-1328414 *☐ VISA or MasterCard*

Credit Card No. _____ Exp. Date: _____

This will appear on your statement as ASTCDPD, Falls Church, VA

Signature: _____

(If registering by E-mail, please fax authorization letter with signature)

Fees: (Check all that apply)☐ Early registration: \$180 (before January 31) ☐ Student registration: \$ 75☐ Late or on-site registration: \$235 (after January 31)☐ Continuing education credits fee: \$ 50* DOB ____/____/____
month day year

Total amount enclosed _____

*So that we can accurately match your registration information with your application for continuing education credits.

Three easy ways to register: Fax: (703) 241-5603 E-mail: skelly001@aol.comMail: ASTCDPD
Attn: Sharon Kelly
111 Park Place
Falls Church, VA 22046-4513
(703) 538-1798I give permission to the Centers for Disease Control and Prevention to use, at its option and without compensation or time limitation, my picture for the promotion of future national chronic disease conferences, including its use in conference promotional brochures and on its Web site <http://www.cdc.gov/nccdphp/conference>.

Signature: _____ Date: _____

Cancellation: Cancellations received by close of business **January 31, 2002**, will be refunded minus a \$25 administrative fee. No refund will be provided for cancellations received after the deadline. If you do not cancel your registration in writing and do not attend you will not receive a refund. You may, however, send a substitute in your place.

Your confirmation letter will serve as your receipt.

REGISTRATION FORM - II

Name: _____
First
Middle Initial
Last
Degree(s)

Please check **ONE** box from each category that most closely describes your profession and work setting. This information will help us to better serve conference participants as we plan the next conference.

Profession

- | | | |
|--|---|--|
| <input type="checkbox"/> Congressional Staff | <input type="checkbox"/> Health Administrator | <input type="checkbox"/> Researcher |
| <input type="checkbox"/> Dietitian | <input type="checkbox"/> Health Educator | <input type="checkbox"/> Statistician |
| <input type="checkbox"/> Educator | <input type="checkbox"/> Media/Public Relations | <input type="checkbox"/> Student |
| <input type="checkbox"/> Elected Official | <input type="checkbox"/> Nurse | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Epidemiologist | <input type="checkbox"/> Physician | _____ |

Work Setting

- | | | |
|--|---|---|
| <input type="checkbox"/> Federal Health Agency | <input type="checkbox"/> State Education Agency | <input type="checkbox"/> Other Federal Agency |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> State Health Department | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Local Health Department | <input type="checkbox"/> University | _____ |
| <input type="checkbox"/> Managed Care/Primary Care | <input type="checkbox"/> Voluntary Organization (specify) | _____ |

Type of Work Activity

- | | | |
|--|---|--|
| <input type="checkbox"/> Administration/Management | <input type="checkbox"/> Health Promotion and Education | <input type="checkbox"/> Surveillance |
| <input type="checkbox"/> Community Health | <input type="checkbox"/> Patient Care | <input type="checkbox"/> Teaching |
| <input type="checkbox"/> Consulting | <input type="checkbox"/> Planning | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Evaluation | <input type="checkbox"/> Policy | _____ |
| <input type="checkbox"/> Health Communication and Social Marketing | <input type="checkbox"/> Research | |

Will you be attending this conference representing a Prevention Research Center (PRC) or Urban Research Center (URC)? ☐ Yes ☐ No

If yes, are you: ☐ Faculty ☐ Board Member ☐ Staff